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Retrieving the doctor-patient relationship in the "language of things" of a medical history museum

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Abstract. University of Siena centuries-old tradition research and didactic is witnessed by the nowadays rich collections of museums gathered in the Sienese University Museum System (SIMUS). These elements together with the presence in Siena of one of the oldest and most innovative hospitals in Europe, represent the ideal scenario in which it is possible to carry out study experiences that in the field of Medical Humanities tend to train physicians who are aware and prepared also on aspects pertaining to the patient's most emotional and spiritual sphere. Through the scientific assets present in its museums and the stories 'told' to the visitors by these instruments, the University of Siena is able to develop specific activities aimed at bringing back the practice of medicine to its original purposes: "being medicine for humans". University of Siena proposes in fact to regain, through the analysis of its cultural heritage, the observation skills and knowledge that are respectful of the human body and feelings. In this way it is possible to activate a doctor-patient dialogue that is also a kind of listening in a comparison between two different narratives, in order to arrive to a better approach not only to the disease but to the best care and assistance of the patient.

Key words: medical humanities, history of medicine, health care professionals' training, university science museums

Introduction

Forty years ago the Law 833/December 1978 established the so called Servizio Sanitario Nazionale (S.S.N. - National Health System) in Italy. The right to good wellness and good health was enshrined on the basis of specific criteria such as the universality of the beneficiaries, because citizens, entirety of the medical provisions - previewing not only diagnosis and treatment but also prevention and physical therapy - equity of treating, and respect of dignity and freedom of the patient (1).

Since then medicine and the treatment options, as well as the figure of the doctor and that of patient, have undergone quite a few modifications. Nowadays, although the risks of a kind of medicine further and further conditioned by factors of economic sustainability, the society claims strongly the attention to the dignity of the patient, his/her and his/her relatives' involvement in therapy decisions, the possibility to be assisted with ability and sensitivity.

As the 'the way to be sick' is dealing with the innermost needs of a person's identity, emotion, and fear, health care cannot be limited to simple standard ordinating procedures. As Edmund Daniel Pellegrino – who was Chairman of the President's Council on Bioethics in USA and Director of the Kennedy Institute of Ethics and of the Center for the Advanced Study of Ethics – wrote: «is a special moral enterprise because it is grounded in a special personal relationship between one who is ill and another who profess to heal» (2). Therefore, the possibility of cure «will depend on which the science offers, but also on a larger system of values, skills, and feeling pertaining either to the doctor either to the patient» (3).

To this end, the physician will have to possess sensitivity and great personal skills, as well as a good scientific training.

«There may be some who will reject the possibility that such a doctor lives, or could have lived. And there may be some who will hope that is he hasn't, or doesn't, he most certainly should…».

I borrow this statement from the initial caption of the film *People Will Talk*, directed by Joseph L. Mankiewicz in 1951 and distributed in Italy with the title *La gente mormora*, which has as its protagonist Noah Praetorius, a doctor attentive to the needs of his patients, who follows a precise philosophy in exercising his profession, based on the idea that «there is a big difference between curing a disease and making the sick feel good».

These few frames contain some fundamental elements for a reflection on Medical Humanities and on the meaning of being a doctor. Everything revolves around the figure of the patient and his/her needs. The doctor listens to the patient, talk to him/her in order to know the personality, understand his/her illness, and how to cure it.

If we wonder about the doctor's function, the most immediate answer is to treat the pathology which is affecting a patient in order to restore a state of good health. But if we deep our pondering, we can conclude that the state of good health is not the simple opposite of illness: it has in itself the research and restoration of a condition of well-being that includes the quality and dignity of human life. To achieve this it is necessary that the doctor devotes time and dedication to each patient, recovering an ancient characteristic which is that of "slowness", in its positive sense, that is, in few words: reserving for each patient all the time that considered necessary.

And here we encounter the first obstacle because such a method clashes with the "business approach" that characterizes healthcare today and which tends to measure each assistance or care provision with pre-set parameters valid in every situation and to treat diseases with objective criteria and controlled experimental procedures, without taking into account that the needs of one patient may be different from those of someone else

Materials and Methods

We must therefore find a method that puts the patient at its center (patient centered) and that, with the emergence of evidence-based medicine, we have abandoned to consider the disease only a set of data, clinical signs and symptoms. If Evidence-Based Medicine has allowed ever better and more in-depth diagnostic and therapeutic possibilities - thanks also to the development of new technologies - it has however determined a progressive loss of the ability (and necessity) to listen to the patients and to understand their fears and waited, thus abdicating a doctor-patient relationship based on the human and relational component.

Therefore, a real revolution is needed in the approach to the patient and in the way he works with it. Above all it becomes fundamental not only to cure the disease but to care of the patient, putting it back at the centre of the experience of the disease.

In the medicine daily experienced, «the skills of the doctor aimed at treating the disease (disease), often de-contextualized by the person who is afflicted, come into play». In patient-centred medicine, «the life (illness) of the patient emerges, revealing not only personal events, but also [...] internalized cultural models that guide the experience of illness» (4).

For many reasons, applying the above model is difficult, if not impossible, with those who work in healthcare facilities today, and no less problematic with the medical students. Often they are so caught up in the quantity of notions to be learned that they necessarily choose to set aside everything that is not strictly "scientific" but attributable to the category and the sphere of feelings. «In the six-year curricular of medical studies, theoretical-practical preparation basically follows the biomedical approach and quantitative evidence, neglecting to deepen the patient's personal knowledge. This marginalization exercises a sort of imprinting: once learned it is maintained even in the following years, in the fullness of the profession» (4).

And yet, if one wants to be a doctor attentive to the relationship with the patient, capable of deepening listening, dialoguing, and creating empathy with those who are sick, it is necessary to broaden the fields of

study to the theme of values and to adopt a method of care based on the knowledge of not only the disease but also of the person who is affected by it.

In other words, there is a need for a cultural reversal that by far means that technological medicine, to which obviously we cannot and will not renounce today, however, restores space to the knowledge and analysis of the patient's symptoms and subjective states that 'feels' and lives one's 'own' disease in a very personal way. «It is not true, in fact, that the diseases are substantially the same in all those who are afflicted by it. On the contrary, the opposite is true, it is worthwhile that each individual feels his/her own "maldessere" (literally "disease to be") in a personal and subjective way» (5).

Therefore, it is necessary to find the right balance between what some North American scholars define with the term disease - alteration in the functioning and structure of the organism - and what they instead describe as illness - subjective experience of the disease perceived by the patient who lives first-hand.

By integrating the scientific information on the disease with the knowledge of the patient's experience we can usefully come to know the situation in its complexity and attempt a positive resolution. The fact that the doctor can consider the *illness experience* helps in understanding the causes of the disease but above all in determining the therapy and the phases following diagnosis.

In this perspective, Medical Humanities can represent a fundamental meeting point between clinical disciplines and other study paths, such as social and behavioural sciences, philosophy but also figurative and performing arts, in order to bring the practice of health back to the its original function: to be a medicine that takes care of and at the same time works for the protection of health and for the well-being of man in its entirety to be physical and spiritual. Such an approach can help the doctor develop specific observation skills that allow him/her to carefully examine the patient and learn about his/her human and clinical history, to better investigate the phenomenon of the pathology that is affecting that specific patient.

On the other hand it is useful to always keep in mind the definition that Edmund Pellegrino has given of medicine: «Medicine is the most humane of sciences, the most empirical of arts, and the most scientific of humanities» (6).

Having said that, let's try to contextualize the issues considered up to this point in the scope, only at a first glance far, of university museums specialized in the history of medicine and medical instrumentation.

The example we propose is that of the Medical Instrumentation Museum of the University of Siena (Medical equipment museum) (7), structured in a series of courses dedicated to the basic disciplines of medicine and some of its specializations. Each path includes a specific experience that is realized through direct, visual, and tactile knowledge of the ancient medical and scientific instruments collected in about 20 years by the University Center for the Protection and Enhancement of the Ancient Scientific Heritage (CUTVAP) and the story, a sort of storytelling, proposed by the museum guide directly or through videos that report interviews with professionals and witnesses of a specific branch of medicine.

The path that more than any other can directly introduce us to a typical approach of the Medical Humanities is that which, within the aforementioned Museum, has been dedicated to the «*medico condotto*» (old Italian definition of doctors who were responsible of a defined small rural district). This particular figure, in addition to covering the role of medical officer, was until a few decades ago the guardian of the health of entire communities. This kind of medical doctor was able to combine the preparation and professional experience with that knowledge of the patient and the family he acquired during the various medical examinations. Through the practice of listening to the patient›s story, or whoever communicated on his/her behalf, the doctor was able to extricate himself from the multiplicity of components to be understood to prefigure a diagnosis and a method of treatment, in order to achieve recovery of health. Through the *anámnēsis*, the *medico condotto* obtained important information to carry out his/her function, recalling and restoring at the same time a positive doctor-patient relationship and the ancient nexus of familiarity between medicine and human sciences.

The anamnestic method is not exclusive to medicine nor does it originate in it, as many other disciplinary fields such as historiography, philosophy and poetry have used it extensively. But the doctor has made it a crucial moment in the treatment process together with semeiotics, that is to say the observation of subjective symptoms and signs of illness which, in the absence of laboratory tests and specific diagnostic techniques, have long been some of the few medical practice resources.

In the splendid cycle of frescoes by the Pellegrinaio of the Hospital of Santa Maria della Scala in Siena, we can observe the scene of the Cure and Government of the Sick painted by Domenico di Bartolo (Fig. 1) between 1440 and 1441. We therefore find an extremely true testimony of the very limited possibilities of clinical analysis that the doctors had available at that time: they were limited to a careful examination of the urine in the matula. But this scene of everyday life of the Sienese Hospital also confirms what was reported in the Statutes of Santa Maria of 1305/1318, namely that it was necessary «to benignly receive the sick and the poor and have doctors to help the sick» and that «each sick person should to be received 'gratefully' and helped in his infirmity». Added to this was the obligation to maintain a maximally correct behaviour towards them, paying great attention to their modesty (8).

Figure 1. Domenico di Bartolo, Care and Government of the Sick (1440-1441), in the Pellegrinaio of the Hospital of Santa Maria della Scala, Siena

Still with regard to the possibility of benefiting from clinical analyses, if we examine the contents of the "doctor's bag" - and this is one of the fundamental phases in the training course for students of degree courses in Medicine and in Health Professions through the museum experience - we discover that this indispensable accessory of such a varied but demanding activity contained a very poor instrumentation, with which the doctor had to deal with urgencies, interventions of external surgery, orthopaedics, dentistry, ophthalmology, gynaecology, obstetrics and paediatrics, and all occurrence by administering drugs he/she carried with him/her (9, 10).

These are instruments that allowed to have a quantitative measure of symptoms – "artificial" and therefore less subjective measurements - such as thermometers and sphygmomanometer, and starting from the mid-twentieth century also of kits for the simplest chemical laboratory analyses of biological liquids. «Contrary to the general trend of other European states, centralized laboratories will not be activated in Italy until after World War II, when the strong demand for exams will be met thanks to sophisticated, fast and precise machines [...]. In the meantime, the necessary analyses are performed by the attending physician or entrusted to small laboratories attached to the Internal Medicine department» (11).

In the University of Siena Museum of Medical Instruments, deriving from donations by various doctors, a Galileo-Hellige hemometer (Fig. 2) with coloured prisms that measured the haemoglobin present in the blood, as well as other similar instruments such as the haemoglobin of Sahli, a thoma blood cell count for manual leukocyte count, glucose dosage glucometers in urines (12).

However, beyond the possibility for the *medico condotto* to use this small reagent that he had to carry with him/her during the visits, it is quite evident that his/her activity was basically patient-centred, focused on the examination of the symptoms that the patient

Figure 2. University of Siena Museum of Medical Instruments. On the right, a Galileo-Hellige emometer with coloured prisms

presented and, through the interview, on the co-construction of the meaning of the experience of illness that the patient him/herself could report.

In this way a relationship of trust was established and an exchange of promises between the doctor and the sick, whose goal was to promote healing and above all the well-being of the sufferer. And this appears to be very evident in the words with which Giuseppe Cernelli, in his book *Ultimo medico condotto*, describes the health situation of a very different Italy from today, despite only a few decades have passed: «Health and often people's lives it was entrusted only to the professional and human ability of the "*medico condotto*", who was forced to operate with great shortage of therapeutic means, far away from hospitals and pharmacies, and in circumstances where he often lacked everything due to urgency, even oxygen» (13).

Over the years the inter-personal relationship between patient and doctor has been increasingly reduced in contemporary medical practice, precisely for the reasons mentioned above: a 'corporate' approach to treatment, the possibility of relying on diagnostic practices unthinkable up to some decades ago, the consideration of the disease simply as a 'mechanical failure' to be repaired and the sick a sort of soulless machine. Almost as if the doctor has suffered from an impoverishment of his/her diagnostic abilities and the patient has in some sense lost individuality and human connotation.

In recent times, however, it seems that medicine wants to react to the danger of a dehumanization of the doctor-patient relationship to find, through the medical humanities, human well-being in its entirety, in its psychological, anthropological and sociological causes, and to identify new skills and abilities for the doctor. The doctor's training can therefore only develop around two key concepts, those of "patient/person" and "relationship between this and those who take care of the care".

Absurdly, what appears today as one of the major difficulties in this relationship was felt in the same way at the beginning of the twentieth century, so much so that Francis Peabody wrote in his essay The Care of the Patient: «The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine – or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients"» (14).

In this sense he stressed openly: «[…] the vital importance of the personal relationship between

physician and patient in the practice of medicine», and addressed his students with these words: «In all your patients who symptoms are of functional origin, the whole problem of diagnosis and treatment depends on your insight into the patient's character and personal life, and in every case of organic disease there are complex interactions between the pathologic processes and the intellectual processes which you must appreciate and consider if you would be a wise clinician» (14). The cure, infact, «is an art, based to an increasing extent on the medical sciences, but comprising much that still remains outside the realm of any science» (14).

This is why the young person who is preparing to be a doctor must necessarily also acquire different knowledge. He/She must know how to listen to the patient, being ready to understand what the sufferer has to say, bearing in mind that the patient can in some cases emphasize a symptom out of fear or a particular experience. The doctor must know how to communicate with a simple and accessible language, reassuring and explaining to what are the investigations intended to do and illustrate the diagnosis and the relative therapy. In other words, the doctor must deal in a dialectical way with the "person" before him/herself, and without having prejudices that may derive from cultural differences, life choices and values, perhaps not conjoined values.

In this way he will be able to develop and implement a course of care in line with the indications that derive from Evidence-Based Medicine and at the same time personalized thanks to the indications received from the patient.

This method, which in the Anglo-Saxon world is known as Narrative-Based Medicine, integrates precisely with evidence-based medicine and helps activate the active participation of the patient. On the other hand, explains Rita Charon, who founded the course of Narrative Medicine at Columbia University in New York, «patients need doctors who understand their illness, listen to their problems and accompany them through their illness» (15-17).

Results and Conclusion

It is therefore a question of creating an empathic system capable of ensuring that the doctor can learn about as much information as possible from the patient, including the subjective experience of the disease, that can lead to a diagnosis and treatment as much as possible 'weighed' on the subject itself. In this regard Adelfio Elio Cardinale, President of the Italian Society of the History of Medicine, writes: «Each patient has a history that goes beyond the symptoms. The patien's bed should return to the center of work» (18).

Certainly, to affirm the above while working with students inside a museum of medical instruments or of anatomy, using a category of very particular scientific cultural assets such as anatomical preparations of the famous anatomist Paolo Mascagni (19-21), could rightly lead to think that a similar formative path is not particularly suitable, in a Medical Humanities perspective, to mend that fracture between "natural sciences" and "spirit sciences" that a positivist approach to medicine has brought about.

What value can osteological or fetal collections stored in formalin or in alcohol have in a similar context? And how do you make them live together in an epistemology of medical science? Aren't these just mentioned, despite the didactic purpose, examples of an objectification of the body and the human person?

The anatomical preparations derive from the dissection, an action that in every age has raised many perplexities, if not open criticisms, for a sort of desecration of the human body. And the lesson of Anatomy, especially if carried out in a museum that preserves these preparations, could be considered as the highest moment of the process of depersonalization of the body which becomes for the doctor an example to show and for the students a mere object of study, no longer with a name or a story.

But to answer this, I recall once again the film by Mankiewicz. Among the first scenes there is a masterly interpretation of Cary Grant who, in the role of Dr. Noah Praetorius, plays the teacher in a lesson on Anatomy held on the corpse of a young woman. These are his words: «A corpse in a classroom. As a student of medicine it is essential at the beginning to understand that a corpse in a classroom is not a dead human being. Anatomy is more or less the study of the human body. The human body is not necessarily the human being. Here lies a corpse. That this was a beautiful girl full of life until a few hours ago has little

importance here. You will not be required to dissect and examine the love that was in her, or the hatred or hopes or anxieties or memories or desires that accompanied every moment of her life: they ceased to exist when she ceased to exist. Instead, in the coming days and months, you will dissect and examine and identify corpse's organs, bones, muscles, tissues and so on. One by one. And all will faithfully record and learn. And when you get out of here you'll know all about this corpse, everything a doctor needs to know».

In this way Praetorius, highlighting with deliberate accentuation the dehumanization of the body during the dissection, leads the students to reflect on the fact that that dead body on the sectarian table is not actually separable from the reality of the person who was. He completely overturns the common idea of the Anatomy lesson which, despite its didactic purpose, objectifies the human body by transforming it into a simple instrument of knowledge. And with this intentional overturning he makes the students reflect on the humanity of the corpse, on the fact that a body is not just *Corporis Fabrica*, a perfect anatomical machine.

In doing so, he removes from the corpse that role of co-protagonist that it would have with the doctor in the representation of dissection in the anatomical theater before an audience of students eager for knowledge. And Praetorius acts in this way so that the students can understand that in their profession it is never possible to separate bodies from people, nor to cure bodies without taking care of people, because it makes no sense to study the disease without taking care of the sick person, who suffers for a certain pathology.

Praetorius is well aware that in the university setting students will be asked to know how to identify every part of the human body with precision, but in the medical profession this will not be enough. And to the statement that the duty of a doctor is to «diagnose the physical ills of human beings and treat them» he replies with these words: «Wrong. My business is to make the sick feel better».

And to do this, the students of Medicine in the course of university studies must acquire - as already mentioned just before - technical notions and ethical values that can support them in their profession and in the awareness of the profound social responsibility that being a doctor entails.

Therefore, through training experiences in university museums, the project that the Sienese University Museum System (SIMUS) has been carrying out for over a decade tends to return a humanistic vision to medical studies in order to focus attention on the person who suffers, opposing an excessive and dangerous dependence on technology and returning a fair value to the doctor-patient relationship that takes into account medical skills and personal skills at the same time.

The main purpose of the Medical Humanities is indeed, using an expression of Viktor von Weizsäcker, the «reintroduction of the subject in medicine», and therefore of his knowledge on the disease.

«Weizsäcker claims the introduction of the subject in the field of biological sciences, by which he intends to dissolve the spell of objectivity, rediscovering those components of illness as a fact of the living being that escape the microscope» (22, 23).

In this sense the educational and informative pathways activated, on which the exhibition sections of the Museum of Medical Instrumentation are modelled, respond to this objective, showing the physician's interaction skills with the patient or the midwives' experiential knowledge that before Hospitalization of the parties assisted women in the home with professionalism and empathy.

Or, inspired by a straitjacket, they can retrace, in the opposite sense of what actually happened, the story of the mentally ill to restore dignity through what, in the second half of the nineteenth century, Carlo Livi called «moral care» (24): an attitude towards the patient in which the knowledge of the patient's experience outside the mental hospital was fundamental for the doctor. In this sense Livi affirmed that «in this speciality more than in others the doctor, escorted by clinical experience, aided by physiology, must be a subtle analyser of all the morbid elements and diligent observer of the facts that fall to his/her eye, because of severe and precise studies still need the pathology of the central nervous system» (25).

We can therefore affirm that the experiences that the Medical equipment museum offers are real educational laboratories which, inspired by the scientific cultural heritage that the museums of the Museum System of the Siena University preserve, are aimed at making students understand the university courses of

the scientific and medical field the need to acquire - integrating its study fields with different disciplines - also listening and relationship skills, of using an adequate and comprehensible language and of empathic expressions, fundamental later to take better care of sick people.

The objects exhibited in university museums are not so 'useful' for understanding the evolution of medical science but become the protagonists of a meaningful relationship with students, in an emotional journey that deliberately stimulates the use of new communication channels.

We hardly think that some actions that a doctor performs daily are very similar and very close to those carried out by a fossil scholar or an archaeologist or even a museum curator. All these professionals must acquire a series of information in order to carry out their own interpretative thesis. Everyone has to deal with an interpretative-narrative process that could lead them not so much to discover absolute truths as to give meaning to the complex and articulated situations that fact.

It is therefore evident, also through these experiences organized in university museums, that the Medical Humanities are absolutely not in antagonism with other scientific disciplines and can represent a profitable space of meeting and collaboration between different methodologies, all useful to train young people who will take charge of the care of women and men in conditions of great fragility, physical and spiritual. Humanistic education does not hinder the acquisition of scientific skills and can indeed enrich them by drawing a narrative paradigm from the human sciences.

Doctors, nurses, health workers can thus «develop a relational mind that flows continuously from introspection to confrontation with the other, discovering references and assonances with one's own history, or with what could be. In this case, even the language of those who take care will take on a different connotation: nourished by forms and contents of which the multiplicity of existences is made, it will be enriched not only with words, but with words that make sense» (4).

In this way, through teaching how to listen to the patient and create empathic relationships, one can contribute in a sensitive way to training professionals able to cope with the health needs of society.

On the other hand, educational responsibility and social development are at the base of the museums' activities of the Sienese University Museum System (SIMUS), which increasingly become educational tools, means to transmit knowledge for the growth of society and above all of the individual understood in the its complexity of being physical and spiritual.

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